or visual stimuli—can worsen mental health among individuals of all ages.[2] In the case of older adults, these deprivations can also worsen confusion and memory loss.[1] Locked behind doors, some hearing-impaired individuals cannot engage even in the informal human contact that sometimes occurs in solitary confinement units by yelling through doors and vents. This exaggerates their isolation, which studies show worsens heart disease and hastens death.[6] Others have described a profound visual depth disturbance—the sense that they don't know where the floor is—and the worry that, at any minute, they could fall.

As a physician, I subscribe to the fundamental medical ethic of "first, do no harm." But a lack of transparency and system-wide health data often limits researchers' ability to describe the range of solitary confinement's harms. It is time for a public health call to improve data transparency, which will allow more expansive evaluations of the range of physical harms of such correctional practices. Given the risk factors for poor health that solitary confinement poses, particularly for those confronting illness or frailty, health professionals should advocate for limits on solitary confinement for older or chronically ill individuals, just as we increasingly protect those in juvenile facilities and the mentally ill. Such action should find bipartisan support given the considerable expenses—in health care spending and avoidable injury and illness—generated by our criminal justice system.

Mr. Woodfox will face extraordinary challenges as he rebuilds his body and soul after an unimaginable physical and psychological ordeal. When Mr. Woodfox gave me permission to write this editorial, we recalled the hope he expressed when we met. Perhaps, hope helped him endure the decades of profound isolation. And perhaps he will be among a decreasing number subjected to our widespread reliance on long-term solitary confinement.

The United Nations Special Rapporteur for Human Rights has pronounced solitary confinement exceeding 15 days to be torture.[7] As the bipartisan tides of US criminal justice reform swell, many are questioning the use of long-term solitary confinement as never before. A broad public health strategy that considers this practice's health risks for all individuals is critical. Until then, those leading reform efforts for a single population at a time (e.g., the mentally ill, juveniles) should also consider older adults and the chronically ill, populations that are too often ignored in reform efforts and whose health would clearly benefit from exercise and social interactions. With an increasingly older and chronically ill prisoner population,[5] it is time for correctional leaders, public health professionals, researchers, and those who have experienced solitary confinement to advocate for the use of alternatives to solitary confinement for all individuals, with a special emphasis on those who are older or chronically ill. AJPH

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Is the Prescription Opioid Epidemic a White Problem?

Economists Anne Case and Angus Deaton report that the life expectancy of US White persons has declined,[1] largely as a result of drug overdose in the context of increased opioid analgesic use. An underacknowledged cause for this racial pattern is opioid regulation and marketing, which gave US White patients the "privilege" of unparalleled access to prescription opioids, illustrating how racially disparate drug policies and health care practices ultimately hurt White patients.

The decrease in White life expectancy began in 1998, two years after the US Food and Drug Administration approved OxyContin as a "minimally addictive" pain reliever. In the midst of the Joint Commission on Accreditation of Healthcare Organizations' national call for pain to be monitored as a "fifth vital sign" for more adequate control, OxyContin's manufacturer sent drug representatives to generalist physicians to promote its use for "moderate" pain conditions, with rapid uptake in primarily White states such as Maine, West Virginia, Kentucky, and Virginia.[2] Consumers thwarted the sustained-release capsules by crushing and dissolving them, and by 2014,

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deaths from opioid abuse reached an all-time high of 18 893, a 3.4-fold increase from 2001.[3]

At the same time, addiction neuroscience, biotechnology, federal regulation, and drug marketing each contributed to the representation of the opioid overdose epidemic as a White problem, subject to interventions distinct from those of the US War on Drugs. The resulting racialized differences between heroin and prescription opioid control resembled those created by the 1986 law distinguishing crack from powder cocaine that led the United States to the highest incarceration rates in the world, with Black and Hispanic men six and three times, respectively, as likely as White men to serve time.[4]

Through the 1990s, the US National Institute on Drug Abuse prioritized neuroscience that located addiction in the brain, supporting the idea that technologies such as sustained-release capsules could reduce addiction by preventing the reinforcing "rush" of high blood levels of opioids, while lessening attention to social context. It also made the racial patterning of opioid marketing and regulation less visible for public scrutiny.[5] In the United States, where insurance coverage and access to physicians are racially stratified, opioid prescriptions disproportionately went to White patients, whereas non-White patients, even those with access to a physician, were less likely to be prescribed opioids, which increased racial differences in opioid use.

When nonmedical opioid use increased in White communities, rather than arresting consumers, regulators mandated physicians to use Prescription Drug Monitoring Programs, instituted voluntary take-back programs for unused medication, and disseminated the opioid overdose reversal medication naloxone, while passing Good Samaritan laws to protect those calling for emergency assistance during an overdose from drug charges. The arrest rate for sale or possession of manufactured drugs was one-quarter that for the sale or possession of heroin or cocaine,[6] even though prescription opioid misuse far exceeded heroin use.

In addition, US Congress legalized office-based opioid maintenance with buprenorphine following expert testimony that methadone was inappropriate for the "suburban spread of narcotic addiction"; that is, middle-class opioid-dependent people were thought to be more often employed and unwilling to comply with daily observed dosing in methadone clinics that carried stigma. Three years after US Food and Drug Administration approval of buprenorphine, 91% of the US patients taking buprenorphine were White, and most were college educated, employed, and dependent on prescription opioids, in contrast to methadone patients who were less often White, college educated, or employed and who primarily used heroin.

Finally, buprenorphine marketing was demographically targeted. Manufacturer-sponsored Internet service announcements for buprenorphine featured images of White professionals (see http://www.naabt.org), and Internet-based buprenorphine prescriber matching services leveraged a computer-literate, privately insured clientele. Buprenorphine prescription requires an 8-hour certification course, and public insurance coverage for buprenorphine is variable, presenting barriers to public sector prescribers.

In the context of public concern that White Americans are turning to heroin, policymakers are calling for reduced sentencing for nonviolent illicit drug offenses and the expansion of access to addiction treatment. At the same time, in Black and Latino communities, many drug-addicted individuals continue to be incarcerated rather than treated for their addiction. Yet racially stratified responses to heroin use are ultimately harmful to all Americans, including Whites. For instance, the US opioid crisis of the 1970s that was centered in communities of color led to harsher penalties and criminalization. If we had invested in harm reduction programs and increased the availability and quality of addiction treatment then, we would have been better positioned to reduce the toll of the current opioid crisis.[7]

Public concern about White opioid deaths creates an opportunity to reorient US drug policy toward public health for all—to make proven harm reduction strategies widely available, such as naloxone for overdose reversal, and to implement interventions proven effective abroad, such as supervised injection facilities and heroin-assisted treatment, which reduce overdose deaths and improve a host of health outcomes.

Medication-assisted treatments, such as buprenorphine, methadone, and naltrexone, as well as psychosocial treatments, including motivational interviewing, cognitive and dialectical behavioral therapies, and relapse prevention, must be accessible within all communities. An array of options, many of which work optimally in combination, will enable opioid-dependent patients and their providers to tailor treatment to individual circumstances. Unless we address existing racial disparities, however, these efforts will only exacerbate inequalities. For example, expanding access to medically assisted treatment may require incentives for physicians who serve low-income patients, such as those in Federally Qualified Health Centers and in methadone clinics, to prescribe buprenorphine.

Moreover, we must rectify current and past harms of US drug policies. Decriminalizing personal possession of drugs and expunging the arrest records of thousands of mostly young men of color who have been caught up in punitive drug policies are steps in the right direction. Racial impact statements—which require legislators to evaluate if and how criminal justice reforms will affect racial disparities before voting on legislation—are another example of proactive policies that seek to address systematic racism.

Unless we scrutinize narcotics policies for their racial targeting, they reinforce inequalities in health care and law enforcement and leave White individuals, along with others, vulnerable in the face of inadequate attention to public health. AJPH

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A Call to Oppose the Child Nutrition and Education Act of 2016 (H.R. 5003)

The Improving Child Nutrition and Education Act of 2016 (H.R. 5003) does not live up to its name.

The legislation would threaten food security for nutrition assistance recipients, decrease the healthfulness of school meals, and may further increase health disparities between children from low- and high-income backgrounds. The American Public Health Association (APHA) opposed this legislation in a letter to Congress along with more than 750 other public health organizations.[1] We urge readers to join APHA in opposing this legislation.

BACKGROUND

The Healthy Hunger-Free Kids Act (HHFKA) was passed in 2010 and implemented during the 2012–2013 school year. The HHFKA provided funding for school meals programs and updated nutritional requirements of these programs. H.R. 5003 is the House version of the renewal legislation to HHFKA, and it attempts to amend provisions of the HHFKA. H.R. 5003 was passed by the House Education and Workforce Committee on May 18. A separate Senate HHFKA reauthorization bill, S.3136, has also passed through the Senate Committee on Agriculture, Nutrition. No date has been set for a vote on either bill at the time of press.

NUTRITION STANDARDS PROVISIONS

The HHFKA created a much-needed improvement to school nutrition standards. A serving of fruits or vegetables became a required lunch component alongside whole grains, and sodium reduction targets were set to be implemented in three phases, from 2014 to 2023.[2]

H.R. 5003 would freeze sodium reduction targets and require a review of both the sodium and whole grain requirements by December 31, 2016. Not only is this time line impossibly short, but the bill also questions the scientific basis of the school nutrition standards. The review and subsequent recommendations must demonstrate "that sodium reductions are both safe and produce beneficial health outcomes for such children." A common rationale for the opposition to sodium reductions is that children are not at risk for high blood pressure in the short term. However, excess sodium intake can contribute to increased risk of high blood pressure later in life. A 2010 report by The Institute of Medicine (now named the National Academies of Sciences, Engineering, and Medicine) confirmed this risk, concluding that "[T]he evidence and public health concerns warrant extending recommendations for sodium intake reduction to members of the general population across the lifespan."[3(p23)]

Another rationale behind the review of whole grain and sodium requirements is the myth that many schools are struggling to meet nutrition standards. According to April 2016 data from the US Department of Agriculture, 98.5% of schools are currently meeting nutrition standards.[4] Of course, technical assistance should be (and is) provided to schools currently not meeting school requirements, but nutrition standards should not be weakened because of the less than 2% of schools not meeting requirements.

In the short time since its implementation, data suggest that new meal standards are improving dietary quality. A 2014 Harvard study showed that in an urban, low-income school district, fruit consumption increased by 23% and vegetable consumption increased by 16%. Plate waste has not increased since the HHFKA's implementation.[2]

PROVISIONS ON ACCESSIBILITY OF SCHOOL MEALS

H.R. 5003 would also weaken access to school meals for low-income children. The biggest threat to accessing school meals is a proposed pilot "block grant" for up to three states. This block grant would be a fixed dollar amount for school meals, rather than the reimbursement per child. This change means that if the need for free and reduced price (FRP) school meals increased (defined as ≤ 185% of the poverty line), the states would not be under any obligation to provide meals to low-income children once the grant amount had been spent. This block grant system would remove the safety net of school meals during times of recession, when more children are income eligible for FRP meals.

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